ARKANSAS GOVERNOR'S COMMISSION ON PEOPLE WITH DISABILITIES

SCHOLARSHIP APPLICATION INSTRUCTIONS

The Governor's Commission awards several students scholarship from this application process. Applications are graded by the Governor's Commission Scholarship Committee on the basis of achievement, community involvement, goals and the challenges each student faces due to his/her disability. The scholarships will be awarded at a banquet in June 2008 in Little Rock. Please follow the directions given below.

PLEASE PRINT OR TYPE YOUR APPLICATION. ALL blanks must be completed. If you have difficulty providing this information in typed or printed form, you may submit an audiocassette tape. If additional space is required, please use a separate sheet of paper. Please write your name, social security number and the section heading with the continuation of your response.

EACH ITEM BELOW MUST BE INCLUDED OR YOUR APPLICATION WILL NOT BE CONSIDERED!

PLEASE ATTACH THE FOLLOWING;

1. Governor's Commission on People with Disabilities documentation form of your disability from a physician.
2. A letter from an official of your school/university confirming that you have been accepted or are currently enrolled and in good standing.
3. Three (3) letters of recommendation from an adult who can testify to your academic abilities, character, volunteer services, and community involvement.
4. Official transcript from high school and/or college.

If you would like for us to share this application with other scholarship programs, if applicable, please sign here:

Signature (if over 18) _____ Date _____
Parent/Guardian _____ Date _____

All requested documents MUST be attached with this application;
Otherwise, your application will not be considered.

No application forms from prior years will be accepted.
Applications must be postmarked by February 27, 2008.
Send completed applications and attachments to:

Arkansas Governor's Commission on People with Disabilities
Scholarship Committee
26 Corporate Hill Drive
Little Rock, AR 72205
Telephone (501) 296-1637 V/TCDD Fax 501-296-1883

ARKANSAS GOVERNOR'S COMMISSION ON PEOPLE WITH DISABILITIES

SCHOLARSHIP APPLICATION

Name (Mr.) (Miss) (Mrs.) _____

Date of Birth _____ Age _____

Address _____ City _____

State _____ Zip _____ Telephone _____ Email _____

Name of school last attended _____

Month/Day/Year of Graduation _____ Or GED _____

Name of college or post secondary school you (currently attend)(plan to attend) circle one _____

SAT Score _____ ACT Score _____ GPA _____

Do you have dependents? If yes, how many? _____

Do you receive SSD or SSDI? _____ Yes _____ No

Social Security Number _____

Have you previously received a scholarship from the Governor's Commission? ____ Yes ____ No

Have you received any other scholarships or grants, such as Pell? If so, please list.

	Source	Amount
1.		
2.		
3.		

What is your disability? _____

_____

_____ How long? _____

List present and past school involvement.

	Date(s)	Organization	Activity or Position
1.			
2.			
3.			

ARKANSAS GOVERNOR'S COMMISSION ON PEOPLE WITH DISABILITIES

SCHOLARSHIP APPLICATION

List community volunteer activities

	Date(s)	Organization	Activity or Position
1.			
2.			
3.			

How many community volunteer hours do you have? _____

List church activities

	Date(s)	Organization	Activity or Position
1.			
2.			

1. Briefly describe your career goals

_____

_____

2. What positive or negative effects has your disability had on obtaining your personal goals?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ARKANSAS GOVERNOR'S COMMISSION ON PEOPLE WITH DISABILITIES

SCHOLARSHIP APPLICATION

Is there any additional information that you would like to share with the Governor's Commission on People with Disabilities Scholarship Committee?

_____

_____

_____

_____

_____

_____

_____

If under 21, please list parents names _____

_____

I hereby attest to the fact that all information submitted in this application is true and correct to the best of my knowledge.

Applicant Name _____ Date _____

Parent's signature if under 21 _____

Mail completed application to (must be postmarked by February 28, 2008)

Arkansas Governor's Commission on People with Disabilities
Scholarship Committee
P.O. Box 2781
Little Rock, AR 72203
Telephone (501) 296-1637 V/TCDD Fax 501-296-1883

ARKANSAS GOVERNOR'S COMMISSION ON PEOPLE WITH DISABILITIES

SCHOLARSHIP APPLICATION
Part II

This Form Is To Be Completed By A Health Care Provider
(Please type or print)

Please Check One [ ] Physician [ ] Licensed Health Care Professional
[ ] Rehabilitation Counselor [ ] Other

Applicant's Name _____ Date of Birth _____
Address _____
City _____
State _____ Zip Code _____ Country _____

Medical diagnosis of condition causing the applicant's disability

_____
_____

Is this a permanent condition? _____Yes_____No If no, expected duration ___/___/___

Does the applicant use any of the following aids for mobility? (Check all that apply)
____ Manual Wheelchair ____Motorized Wheelchair ____Cane ____Crutches
____ Powered Scooter ____Personal Attendant ____Walker ____Service Animal

Please complete this section, if the applicant has a visual impairment:
Visual Acuity with best correction: Right Eye ____ Left Eye ____ Both Eyes ____
Visual Fields: Right Eye ____ Left Eye ____ Both Eyes ____

I am knowledgeable of the applicant's medical condition(s) and based on my professional opinion, I certify that the above information is true and correct.

Name of the Care Provider (Please Print) _____ Telephone _____
Address _____
City _____ State/Zip Code _____
State License Number _____
Signature _____ Date _____